

MANY A MICKLE

The old Scottish proverb tells us that "many a mickle makes a muckle" - understandable if it is the same as looking after the pennies. The point is often overlooked that small things can and do make a difference. The lessons of Total Quality Control learned from car makers and others is just the same - that it is the continual process of improving small things that makes a product or service better for the customer. In doing so, it also makes it better and more interesting for the workers delivering the product or service.

In this issue of *ImpAct* we have a superb example of this. Vijay Nathoo, a GP in Manchester, has used evidence to improve prescribing to a small number of patients with gastro-oesophageal reflux. The key was repeat prescribing review, plus individual patient contracts aided by a questionnaire designed to look at critical features of the condition.

The result was a saving of just under £3,000 over six months in a practice of 7,600 patients. At one level this could be seen as a "so what?" result. But it amounts to about £75,000 a year potential savings in an average PCG of 100,000. And with about 500 such PCGs in England, that's a whopping £37 million.

Quality and cost

This is something driven by quality issues. The cost benefits just drop out. As an example, it makes the point that higher quality can often lead to reduced costs, though that will not be a rule. More people can benefit, or can benefit more.

At the other end of the spectrum we have the work at Peterborough. Here a straightforward application of modern technology has speeded up the referral process and "potentially" saved much clinic time. This will have quality and cost implications as well.

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The views expressed in ImpAct are those of the authors, and are not necessarily those of the NHSE

BETTER QUALITY AND LOWER COST IN PRESCRIBING FOR REFLUX

Better treatment of reflux through partnerships between patients and GPs at Beswick surgery resulted in higher quality at lower cost

Why was the initiative launched?

Repeat prescriptions account for about 75% of items and 80% of the costs of all prescribing. Within this overall picture reflux is a common relapsing condition and a common cause of consultations in general practice. Although the majority of patients suffering from this condition self-medicate with over the counter preparations, those visiting their GP still represent a significant workload for primary care. Expenditure by practices on H2-antagonists for these patients is likely to be significant. Adequate controls on repeat prescribing are an essential feature of effective primary care. The Beswick surgery in Manchester decided to look for ways to reduce repeat prescribing.

What was done?

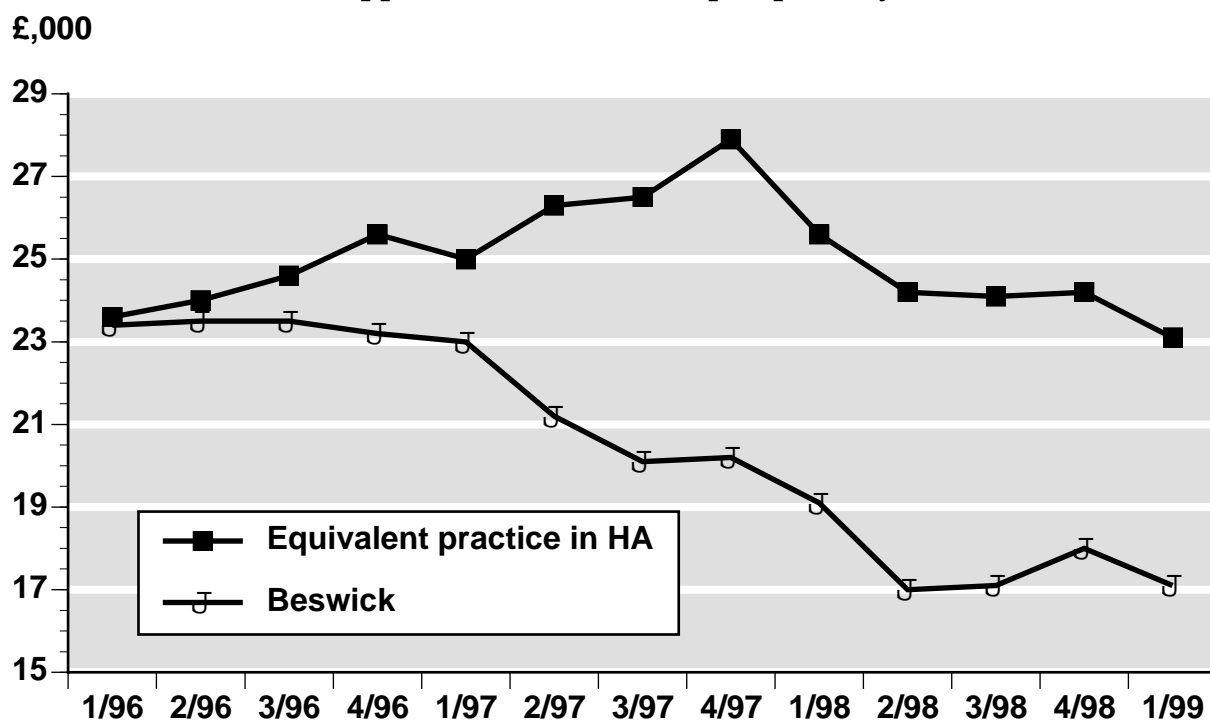
The first steps were to collect together information to help the practice understand current knowledge about the condition and treatments. This allowed them to become confident about the effectiveness of alternative treatments. It was clear from their enquiries that omeprazole had been shown to be the most effective maintenance therapy in patients with reflux oesophagitis.

To help them understand the consequence of their initiative the practice identified 32 patients with reflux who were being prescribed H2-antagonists or other treatments (11 different treatments). They developed a protocol for a review of treatment, including the patient's view of their treatment. The protocol guided discussion about the incidence of pain, the use of medicines - what is used and how frequently and related lifestyle issues.

The review was designed to explore current medication and the presence or absence of symptoms and the record of compliance with medication. A key feature of the consultation was the objective of 'negotiating' with the patient a change to a daily dose of omeprazole 20 mg with related emphasis on the need to take the full-prescribed course.

A notional 'agreement' between the GP and the patient was the intended outcome of this review. Patients' progress was reviewed after an eight-week treatment programme.

PACT prescribing for Beswick practice and a Health Authority equivalent practice for acid-suppressants. Cost (£,000) per quarter year.



Did it work?

The eight week review showed that 17 out of the 32 patients required continuing repeat prescriptions. These were changed to omeprazole 20 mg or 10 mg daily because the evidence is that this is better than H2-antagonists for maintenance therapy (www.jr2.ox.ac.uk/Bandolier/bandopubs/gordf/gord.html). The other 15 patients required no repeat prescriptions, were given omeprazole 20 mg as pulsed therapy to tailor their needs, and were invited to attend surgery if the problems returned. Patients welcomed the process of review.

The initiative produced cost savings of £2,900 over six months in the prescribing budget. This saving was identified from data directly related to the project. Subsequently, PACT data confirmed the significant reduction in money spent on acid suppressing medicines (Figure). The process for managing repeat prescribing for reflux has now been adopted by the practice and is ongoing.

Tips for success

- Choose topics for attention carefully.
- Be sure of the evidence – rely on research reviews undertaken by suitably qualified units.
- Use a pilot study to confirm the therapeutic benefit of

change and convince the full practice team of the merit of change.

Engage patients in reviews of their care and treatment – ensure that they understand the benefits of change.

Establish 'agreements' with patients – covering what they and the GP will do!

Look for practical ways to measure the effect of initiatives.

To find out more contact

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The following material is available

- ◆ Background paper (February 1998) which provides relevant references.
- ◆ Protocol for review consultations with patients.

ImpAct bottom line

- ⇒ Use pilot studies to verify the potential benefit from change and remember - *success breeds success*.
- ⇒ Small initiatives can lead to big savings. £2,900 per six months for a practice size of 7,600 would mean £76,316 a year for a PCG of average size 100,000 – a significant saving.

SHARING IMAGES FOR BETTER DERMATOLOGY CARE

Using new technologies to improve links between primary and secondary care in Peterborough

Why was the initiative launched?

Dermatology is a high volume activity: the fourth highest in terms of outpatient clinic attendance and the fourth commonest reason for patient visits to GPs. These factors suggested that dermatology should be one of the first clinical areas tackled when the Peterborough Hospitals NHS Trust was setting up a major programme of development work. The overriding focus was the quality of care and treatment – rather than a narrow concentration on waiting times. The Trust's Transformation programme was designed to bring a – practical – whole system approach to service development.

What is being done?

To launch the programme, local managers facilitated a series of discussions between GPs and Dermatologists. These were able to build on strong links between GPs and Consultants that had been established locally since the early days of GP Fundholding. The discussions reviewed the totality of care and identified four specific aspects of the management of dermatology services which required attention. Managers made clear from the outset that the Trust was committed to making any necessary adjustments to the deployment of resources that might be justified clinically. Progress is being made on all four aspects.

- 1 *First*, a new approach to outpatient clinic appointment was introduced with the declared objective of reducing the proportion of patients failing to attend their first appointment – DNAs. As they near the top of the waiting list patients



are now contacted by the hospital and invited to suggest a date and time convenient for their first appointment.

- 2 *Second*, a series of discussions were arranged to enable Dermatologists and GPs to agree a local guideline for the treatment of common condition – such as ulcers, eczema and warts. A significant proportion of GPs took an active part in these discussions – a consequence of the good relationships between them and hospital staff.
- 3 *Third*, hospital based specialist nurses and the Dermatologists developed a clinical training programme for practice nurses. Over three linked sessions the course equips them to play an active role in the management of chronic dermatoses in primary care and reduce GP workload.
- 4 *Finally*, and perhaps the most innovatory aspect of the programme has been the development of a system for 'e-mail' referrals from primary to secondary care. Staff in primary care are now using digital cameras to 'photograph' the patients and send digital images of their skin condition to the hospital dermatologists. The system is being piloted in seven practices: the key test is whether diagnoses could be based on electronic images. The images are sent – securely - over the NHS Net. Olympus Cameras sponsored the supply of digital cameras and have provided training in their use.

Is it working?

The programme overall was launched in 1997 and already some benefits are evident. There has been:

- A significant fall – from 12.1% to 2.8% within six months - in the proportion of DNAs.
- Strong interest in training courses for practice nurses - with two attending from each practice.
- Active involvement of GPs in the formulation of local clinical guidelines – with one GP from each practice contributing.

The e-mail referral process has been in use in seven practices since October 1998 which already had suitable IT equipment.

One of the early challenges was to help staff in local practices take good images – not the best holiday snaps! It has proven sensible to encourage the individual practices to identify who locally had the best 'eye' for this part of the process. The Trust has since developed a set of tips to support local training. These are:

Remember that composition and lighting are the keys to is the key to better photographs – and:

- ◆ Choose the background carefully – use a plain wall, don't include the window!
- ◆ Limit the image to the particular area of concern – don't include the filing cabinet!
- ◆ Make sure that clothing and jewellery don't obscure the image
- ◆ Ensure that the area of interest can be identified – is there is sufficient detail to make a diagnosis?

- ◆ Think about the angle of view – is the area of interest raised or flat?
- ◆ Provide a general view to show the location and scale of the condition *and* a close-up to show detail.
- ◆ And finally check that the subject is in focus!

In the first four months (October 1998 to January 1999), 70 images (relating to 36 patients) were sent to the hospital dermatology department. The early indications were encouraging with over 60% of the images transmitted usable.

Dermatologists were able to use the images to identify the nature of the problems (in 94% of cases) and provide a diagnosis (64%). The quality of the images transmitted is improving with growing experience of the new approach. At this early stages few changes in practice have been identified – but the scheme is proving popular and means of extending the facility to other practices are being explored. It is a practical, cost-effective solution to the challenge of sharing information.

An important by-product of the scheme is the creation of a local library of dermatological images that will be helpful for training purposes – real local patients. Early indications from patients involved in the pilot scheme are very encouraging. Patients are interested in the use of technology and attracted by the possibility of avoiding hospital visits.

The benefits extend beyond dermatology services. The Trust has been able to learn valuable lessons to tackle the information and IT agenda set by the Government paper 'Information for Health'.

Tips for success

- ✓ Tackle questions about resources 'up front' – be open and honest about what is possible! Don't put it off for another day.

- ✓ Use facilitation skills to secure 'ownership' of the development agenda – don't try to impose one from a management perspective!
- ✓ Value time spent in creating working relationships – help clinical staff in primary and secondary care put faces to names!
- ✓ Ensure that development teams involve appropriate clinicians and managers from the very beginning.
- ✓ Find ways to link development work – don't allow them to have 'lives of their own'. For example the development of IT and information facilities and service developments should go forward 'hand in hand'.
- ✓ Be imaginative in finding ways to fund development work – sponsorship for some aspects may be available.

To find out more contact

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Email William.Stevenson@pbh-tr.anglox.nhs.uk

The following material is available

- Dermatology clinical guideline.
- Information about the training programme for practice nurses.
- Minimum data set for e-mail referrals.
- Training leaflet on the use of digital cameras.

In addition samples of the images can be supplied by email.

The material is also available through the Trust's website on the NHS Net: www.pbh-tr.anglox.nhs.uk

ImpAct bottom line

- ⇒ Look for simple practical ways to use IT – don't be tempted by over-elaborate solutions.
- ⇒ Collaboration between primary care and secondary case specialists can impact significantly on the little things that make a difference – like reducing the number of patients who don't turn up for clinic appointments. Efficiency and effectiveness thrive on doing simple things well.

ImpAct

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ImpAct is about 'good practice' - and about **implementing** change and **action** to get there! We want to help people in the NHS to make a difference, and to identify and report on:

- ◆ Ways of improving performance which have been successful and which are transferable.
- ◆ People who have led successful local initiatives and who are keen for others to learn from their experience.
- ◆ Material developed locally that could be adapted for use elsewhere and thus cut local development time.

Let *ImpAct* know if you have done something that made a difference and want to tell others how you did it.

KEEPING AN EYE ON CARE

Managing the quality of the diabetes care in Shropshire

Why was the initiative launched?

Arrangements for annual eye screening of patients with diabetes are a proven element of effective care. Failure to detect diabetic retinopathy is one of the leading causes of blindness in the working population of industrialised countries. Diabetes is a very common condition affecting a significant proportion (about 2%) of the population. Progression of diabetic retinopathy in its early stages can be halted by laser treatment – but to be effective it must be given at the earliest opportunity.

In 1995, there was no uniform or comprehensive screening programme for the detection of diabetic retinopathy in Shropshire. A pilot programme, funded by the health authority, was launched in January 1996 to remedy this deficiency.

What was done?

The programme was designed to tackle the challenge of providing a screening service in a pre-dominantly rural area. The absence of a diabetes register and the lack of specialised training of optometrists were two compounding factors.

The programme had two main components – one tackled services in the community and the other focused on patients who attend hospital clinics. Initially a working group was set up involving optometrists, a consultant ophthalmologist, consultant diabetologists and colleagues from the health authority. As the project progressed clinical staff working in the hospital's Diabetes Eye Screening Department were also involved.

Creation of a training course for optometrists and agreement of a referral protocol were essential first steps for the introduction of a community based screening programme. All NHS registered optometrists practising in Shropshire have since been invited to enrol for the programme. This involves attending an initial training course at the local hospital, agreeing to adhere to the referral protocol and attending yearly updating sessions.

Once enrolled the optometrist is entitled to examine diabetic patients referred by a local GP and is paid a fee for each patient screened. The protocol requires that the patient's eyes be dilated prior to examination. GPs, in consultation with patients, choose the optometrist to whom the patient should be referred.

Within the two hospitals providing the Shropshire Diabetes Service, arrangements were introduced to ensure that all patients who attend Diabetic Clinics have their eyes photographed by the diabetes eye screening practitioners. The photographs are reviewed by the consultant diabetologists and ophthalmoscopic examinations are undertaken.

The information collected through the screening programme has been assembled to provide a database of patients. It contains basic data to identify patients, the date of diagnosis and

method of diabetic control and information about screening and associated clinical examinations. Analysis of the data has proved to be very useful in managing and monitoring of the screening programme. Individual practices in the community – both GPs and Optometrists – are being kept in touch with the progress of their patients. Moreover, patients who have not been screened are being identified and followed-up.

Is it working?

Very much so - in the first three years the screening programme has reached almost 8,000 patients and about 70% of these have been rescreened. These numbers represent about 90% of the target population and about 2% of the population of Shropshire. About 10% (740) have been referred to the ophthalmologist and 20% of these patients have received laser therapy.

The programme is proving popular with patients, GPs and optometrists and the quality of screening is proving to be high. A series of postal surveys has been used to assess the response to the new approach: all of these had an encouraging high response from about 90% of those invited to take part.

- Optometrists returned 52 questionnaires – showing high satisfaction with the training provided.
- GPs returned 60 questionnaires - reporting that they were very content with the programme and the associated documentation – such as the referral forms. GPs said *“The programme is excellent and is a major help to diabetic care in surgery”* and *“Forms are very easy and quick to complete”*.
- Patients returned 190 questionnaires - showing that about half of the patients had been screened before. Most patients reported that the tests were uncomfortable – but all would return for rescreening.

Comparison of 225 patients screened by optometrists and retinal photography showed that in 10 cases (4.4%) there were minor differences reported. However none of these were significant enough to alter treatment. The programme has shown that optometrists can be trained to be expert screeners and that they can adhere to referral criteria. The screening fee is paid to optometrists after the reports are received in the hospital – this ensures that the reports are received!

Tips for success

Analyse carefully the contributions that will be required to carry the work forward – such as clinical experience, training expertise and IT skills – and be clear where these will come from!

Recruit the project team with care – good team workers are essential

Written agreements might ensure that important contributions are received when scheduled – don't rely on the spoken word!

Build on existing systems rather than 'start afresh'

Ensure that you have sufficient 'pairs of hands' to undertake the numerous clerical tasks – such as invitations to patients to attend clinics.

Consider carefully how best to respond when an effective member of the team leaves. What does the current situation demand? It may not be the same as when you started!

Face to face contact with people who can contribute is likely to be more productive than phone calls – make the effort to go and meet them – it pays off.

Telephone 01743 261118
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The following material is available:

- Specification for optometrists training
- Referral protocol
- Clinical audit report

To find out more contact

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Brett House
Shrewsbury SY3 3XF

ImpAct bottom lines

- ⇒ Achieving change can be hard work – share out the tasks – but make sure people know what is expected of them – and when.
- ⇒ Look for practical ways to improve and build on existing systems – don't believe that you have to start afresh on everything.

CREATING A TOOLKIT FOR WORKING WITH THE COMMUNITY

Exploring ways to engage local people in the development of the North Tees Primary Care Group

Why was the initiative launched?

In North Tees there is strong history of collaboration between the Community Health Council and the Health Authority to involve patients in the development of health services. Given the success of these activities there was a lot of interest locally in exploring ways to see how this experience could support the creation of the North Tees Primary Care Group.

The essential aim was to ensure that future developments should build on previous success. The Clarence's Well-being survey which focused on a housing estate in Stockton on Tees is an example of the work undertaken. This was a collaborative venture involving all local health agencies. It was designed to help these agencies understand in detail the views of local people and create a climate within which action to respond to local needs could be tackled. Key messages from the survey – concluded in late 1997 - were a desire for health care to be delivered from the local Neighbourhood Centre and for a chemist shop on the estate.

A Clarence Community Partnership has since been established - as a legal entity - to take local developments forward. The partnership includes representatives from all the local statutory agencies as well as representatives from major local industries. A number of specific developments are being planned – but as ever these take time.

What was done?

The main focus of the work was the production of advice to

the newly formed Primary Care Group about the creation of a 'patient engagement programme'. This was assembled by representatives from the Community Health Council, the Health Authority and the Primary Care Group. The programme should be designed to enable the Group to be clear about the purpose of the work and undertake it in an effective and systematic way. The conclusions from those discussions argued the key features of the programme should be clarity about a process for engaging the community, the means of demonstrating how the programme would work, a mechanism for keeping the community in touch with progress and how continuous evaluation would be managed.

To support the development of the patient engagement programme staff locally have created a 'patient engagement toolkit'.

Public Engagement Toolkit

Involving the public Research with the public

Advisory groups	Sampling
Citizens juries	Research interviews
Consensus panels	Questionnaires
Development projects	Surveys
Health forums	Focus groups
Health panels	Critical incident techniques
Open surgeries	Rapid appraisal
Patient panels	Service user diaries
Special interest groups	

The toolkit provides advice about established methods - the 'tools of the trade' - for obtaining information from, and for delivering information to, patients. The toolkit helpfully distinguishes between method for 'involving the public' and for undertaking 'research with the public'. Each method is described briefly and assessed on the basis of advantages and disadvantages as a method for particular tasks. The toolkit stresses the need for careful assessment of the different methods and points to the merit of seeking help from other agencies if the necessary skills are not available within the organisation.

Following the development work in North Tees the Public Engagement Toolkit has been adopted and endorsed by the Northern and Yorkshire office of the NHS Executive.

Tips for success

- ✓ Ensure that all those involved are clear about the purpose of 'involving patients'.
- ✓ Acknowledge that real involvement and partnership between organisations and the community may take time to achieve.
- ✓ Choose the method for involving the community with care – and suitable for the task in hand – Is the objective to secure support for a change in services or to assemble information to guide planning?
- ✓ Work collaboratively with other local health organisations and share information as new initiatives are planned.

- ✓ Build on the potential 'change agent' role of patients – well-informed patients can 'encourage' services to change!
- ✓ Use language carefully – avoid NHS jargon.

To find out more contact

For information about developments in North Tees

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Stockton on Tees TS18 1SP

Telephone 01642 611664
Fax 01642 611959

For information about the toolkit

Sheila Rook
Planning and Development
NHS Executive: Northern and Yorkshire
John Snow House
Durham University Science Park
Durham DH1 3YG

The toolkit is available at:
www.doh.gov.uk/nyro/toolkit.htm.

LEARNING CENTRES

A key component of the NHS Learning Network

In Issue 1 of *ImpAct*, Jennifer Dixon described the overall plans for the development of the NHS Learning Network. This report is about the role played by the proposed learning centres in the Network.

Aims of Learning Centres

The aim is to promote three types of centres to complement existing learning activity and encourage the sharing of learning and good practice across the NHS. This recognises that while most learning in the NHS takes place on the job, there is an important place for learning away from the work place. Such learning may take place in other parts of the NHS or in educational settings. Both of these provide valuable opportunities for reflection and the sharing of experiences of others working in similar fields or on similar types of problems.

Types of Learning Centres

- ⇒ *Specialist learning centres* – are known as 'specialist' because they have undertaken a significant management intervention that has shown to benefit patients. Such centres will already have a track record in sharing that learning across the NHS, possibly through links with a higher education centre.
- ⇒ *Learning partnerships* – which connect organisations either locally or regionally to tackle a shared priority for

service improvement. These partnerships may be sustained through a resource centre.

- ⇒ *Beacons* - which are recognised examples of good practice that are making a real difference to patient care. Beacons will be chosen in declared priority areas and be supported to share their learning with others. Information about will be included in the SDP database (part of the "Supporting Intelligence" base of the Learning Network).

Selection

The first learning centres are being identified in two ways. *First*, by inviting applications direct from the NHS for some types – for example some types of beacons. *Second*, through a process being adopted by the NHS centrally and through regional offices to identify potential centres.

The intention is not to promote 'one model' but rather to promote discussion about the most suitable blend that will support local learning. The current emphasis is focussing on NHS organisations that are already acting as specialist learning centres or meet the beacon criteria. The NHS executive has been encouraged by the growing interest in the concept of learning centres.

Progress

Centres that have been identified so far are:

Specialist Learning Centres

Centre for Best Practice in Leicester Royal Infirmary NHS

Trust. Contact - Ron Cullen Tel 0116 258 6642; Email rcullen@lri.co.uk

South Tees Acute Hospital NHS Trust, Middlesbrough. Contact - Peter Smith, Tel 01642 854805

Centre for Advanced Interprofessional Development at Salford Royal Hospitals NHS Trust. Contact - Henry Stahr Tel 0161 787 4212; Email: hstahr@mcmail.com

Learning Partnerships

Buckinghamshire Partnership, Stoke Mandeville Hospital, Aylesbury: Contact: Sarah Fraser: Tel 01296 315108; Email sfraser881@aol.com

Beacons

About 300 Beacon services in primary care, waiting lists and times, mental health and health improvement were announced in May 1999. Information about Beacons is available from:

Paul Atkinson, NHS Executive Tel: 01132 545311
Nigel Zamen, NHS Executive Tel: 01132 546320

Both Paul and Nigel are based in PC-WIT at Quarry House, Leeds LS2 7UE.

Learning Centres - an example

To illustrate the sort of support which the *specialist learning centres* will provide it might be useful to describe briefly the programme offered by the Centre for Advanced Inter-Professional Development at Salford Royal Hospitals NHS Trust. Their programme builds on their work on the European Foun-

ation for Quality Management model.

This Centre is a joint venture funded by the University of Salford (Continuing Education Unit and Management School) and the Salford Royal Hospitals NHS Trust. It aims to support shared learning by building bridges between professions and organisation. It brings together academic research and practical experience in such a way that new practices are based on research and new research is tested in practice.

The Centre has an extensive programme that includes:

- ◆ Forums for professionals from different disciplines to share information, experience expertise and ideas.
- ◆ Opportunities to gain experience through site visits, and networking.
- ◆ An educational programme awarding certificates, diplomas etc in collaboration with the Revans Centre for Action Learning.
- ◆ Workshops focusing on the European/UK organisational excellence model.

The approach of the Centre is to create a framework and culture of critical self-assessment as the springboard for actions which improve practice and which are shared through a system of Quality Awards. So far over 150 awards have been granted. These include awards for a joint assessment and discharge system which was commended by the Audit Commission, a dedicated hernia service reduced average length of stay from 3.6 days to 1 day, a surgical spinal service triage system reduced waiting time for initial consultation from 2.5 years to 3 weeks.

Plans are being made to ensure that all staff in the NHS is kept up to date with the development of learning centres. *ImpAct* will continue to contribute.

EVIDENCE FOR IMPACTING

As well as highlighting the unsung heroines and heroes in the NHS who are doing superb work in finding ways of improving quality of care and using evidence, often at reduced cost, *ImpAct* wants to find examples where getting evidence into practice is, or should be, a "no-brainer". These will be where evidence is good, and where the questions should be "are we doing this", and "if not, why not".

PSA and bone scans

There are a number of studies showing that use of PSA serum tests can predict the results of a bone scan to investigate whether a patient has bone metastases. A PSA test costs about £10, the bone scan costs hundreds, and is unpleasant. The Figure shows that people with PSA values of less than 20 µg/L do not have bone metastases. The figure shows that from two studies fewer than 1% of patients with values less than 20 µg/L have metastases.

Bandolier has two articles on this, one from the UK and one from the USA which give a lead into this important evidence.

There are other positive articles in the literature to support this.

<http://www.jr2.ox.ac.uk/bandolier/band2/b2-4.html>
<http://www.jr2.ox.ac.uk/bandolier/band47/b47-4.html>

Percent with bone metastasis

